MEDICAID WAIVERS:

The Intersection of State and Federal Law

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Medicaid waivers play a crucial role in supporting individuals with disabilities by providing access to tailored healthcare services. The Federal government, though specific sections of the Social Security Act, allows states to implement Medicaid waivers, enabling them to offer customized care to more effectively meet the needs of their populations.

What is the Medicaid Waiver Program

The Medicaid Waiver programs were conceived by the Federal government to allow states to modify the standard Medicaid rules under Sections 1115 and Section 1915 of the Social Security Act. Section 1115 allows states to create and test experimental, pilot, or demonstration programs, with the goal of improving quality, accessibility, and efficiency of care. Section 1915(c) allows states to deliver health care services to aged or disabled adults who require nursing home level of care, but do not want to live in a traditional nursing home or institutional setting. Section 1915(b) waivers allow states to create managed care delivery systems or otherwise restrict the choice of providers for Medicaid beneficiaries. States can use this waiver to more efficiently coordinate care and control costs.

Eligibility Criteria

Medicaid's basic criteria are financial and based on medical need. The financial requirements are based on income, assets, and transfers. Currently, the income is capped at $2,829.00 per month gross for each person applying. A married couple who are both applying can have a gross income of $5,658.00. There is no income limit for a spouse who is not applying for Medicaid. An individual's assets are capped at $2,000.00 and a married couple's assets are capped at $3,000.00. Homestead property with equity of up to $713,000.00, one car,

personal belongings and household items, and prepaid burial plans and burial plots are not countable assets. A non-applicant spouse's assets are capped at $154,140.00.

Additionally, within the 5 years prior to date when the application for Medicaid is approved, the applicant must report any transfers of more than $1,000.00 which were not for fair market value of goods or services. In addition to the Federal Medicaid requirements, each state may have different requirements for their state Medicaid and Waiver programs. (https://www.myflfamilies.com/sites/default/files/2024-03/Appendix-A-9.pdf)

Florida Waiver Programs

Florida has been proactive in implementing waiver programs. By far, the largest of these is the Statewide Medicaid Managed Care (SMMC) Long Term Care program, which is a concurrent 1915(b)(1) and 1915(b)(4) waiver. It is available to adults over 65 or to disabled persons, such as those with a brain injury, HIV/AIDS, physical disabilities, or those who are medically fragile and between the ages of 18-64, who meet the financial requirements for Medicaid. Florida also established Aging and Disability Resource Centers (ADRC's) to provide information, referral services, and assistance in applying for Medicaid and other programs. (https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/FL)

Another example is the iBudget Waiver, which is a Section 1915(c) waiver that provides "person-centered" planning for individuals with developmental disabilities, over the age of three who meet the level of care criteria for intermediate care facilities for the developmentally disabled. This approach ensures that each person has an individualized support plan that is tailored to their specific needs, preferences, and goals. It is designed to promote independence

and community integration by providing a range of services including supported employment, residential habilitation, and adult day training. The iBudget program is implemented and administered by the Agency for Persons with Disabilities (ADP). (https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers/developmental-disabilities-ibudget-waiver)

Long Term Social Services

The following services are included as a minimum benefit for anyone who qualifies for these waivers:

Adult Companion Care: Applicants can receive service from a home health care aide who assists with non-medical activities of daily living and personal care, such as bathing, eating, dressing, house-keeping, grocery shopping, cooking, transferring, toileting, etc. The amount of time is based on need as assessed by the healthcare provider. This service can be provided in the client's home or in an assisted living facility. The aides can be contracted by the health care provider or there is a consumer directed option, which allows the applicant to hire the provider of their choice. This can include spouses, children or other family members. The family member must complete a background check and training.

Adult Day Care: Adult Day Care is a service where adults who require supervision can spend part of a day, but less than 24-hours in an institutional group setting which can provide socialization and activities, but can also include meals, occupational therapy, medical screenings, classes, assistance with medicine and personal care, classes, and other services.

Durable Medical Equipment and Medical supplies: If prescribed, Medicaid will pay to buy or rent durable medical equipment, such as wheelchairs, walkers, prosthetics, orthotics, oxygen and related supplies, pulse oximeters and respiratory supplies, nebulizers, alternative communication devices, hospital beds and mattresses and rails, lifting and moving supplies, and toileting aides. If feasible, some repairs of durable medical equipment is also covered. Medicaid will also pay for medical supplies such as wound care, incontinence supplies, gloves and wipes, and diabetic supplies. Medicaid may also provide some home accessibility adaptations.

Nutritional Assessment and Meal Delivery: Patients and their caregivers can receive education and support for dietary requirements and meal planning. Additionally, prepared, frozen meals can be delivered to the home.

Respite Care: Caregivers can request care for their loved one for times that they cannot be there or need a break. Caregivers can also request training and counseling.

Transportation: Medicaid will reimburse for non-emergency transportation for doctor's appointments and Medicaid compensable services, generally with the existing public transit systems or taxis. This service is available to all Medicaid recipients who have no other means of transportation.

Personal Emergency Response System: Medicaid will provide a device, such as a life alert or other emergency response system and pay the monthly charge for use.

Therapy Services: Medicaid can provide occupational therapy, physical therapy, speech therapy, or respiratory therapy, if needed.

Mental Health Services: Medicaid will cover long term inpatient mental services, clinical therapy, individual and group therapy sessions, and treatment for some disorders, such as bipolar disorder.

Case Coordination/Case Management: Case managers ensure individualized programs that can meet the needs of clients and can help monitor when their needs change. They also can coordinate care with doctors, therapists, and other medical professionals.

Hospice Care: Medicaid will also provide in-home hospice care.

The waiver programs also can provide some at home medical assistance such as assistance with preparing and taking medication, and intermittent and continuing nursing services. (https://ahca.myflorida.com/medicaid/medicaid-policy-quality-and-operations/medicaid-policy-and-quality/medicaid-policy/federal-authorities/federal-waivers/florida-medicaid-s-covered-services-and-waivers)

How States Get Waiver Approval

Obtaining a Medicaid waiver is a multi-step process that begins with the state developing a detailed proposal that outlines the scope, eligibility criteria, services to be provided, and the budget for the waiver program. This proposal will ultimately be submitted to the Centers for Medicare & Medicaid Services (CMS) for review.

Prior to submitting the waiver proposal to CMS, the state must provide public notice and allow for public comment.[1] The notice and public comment period occurs twice: once at the state

[1] https://www.hcbs-ta.org/authority-comparison-chart?field_hcbs_authority_target_id%5B7%5D=7&field_hcbs_authority_target_id%5B8%5D=8

level and then again at the federal level.[2] These procedures ensure transparency and give stakeholders, including beneficiaries, healthcare providers, and advocacy groups, the opportunity to provide input on the proposed waiver.

At the state level, states must provide a public comment period prior to submitting an application to CMS for either a new demonstration program or an extension of an existing program. This information must be published prominently on either the main page of the state Medicaid website or a website established for the demonstration.[3] States will also publish the public notice in either the State's administrative record or in newspapers with the widest circulation and maintain an email mailing list or similar mechanism to notify interested parties of the demonstration application.[4]

The state-level public notice must include the following: (1) a comprehensive description of the application or extension "that contains a sufficient level of detail to ensure meaningful input from the public"; (2) "locations and Internet address where copies of the demonstration application are available for public review and comment"; (3) mail and email addresses where the public may send their written comments for review, and the thirty-day time period during which comments will be accepted; and (4) "[t]he location, date, and time of at least two public hearings convened by the State to seek public input on the demonstration application."[5]

The state is required to conduct at least two public hearings, to be held on separate dates and at separate locations, at least twenty days prior to submitting an application to CMS.[6]

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[2] 42 C.F.R. § 431.408(a)(1)
[3] Id¡
[4] Id¡
[5] 42 C.F.R. § 431.408(a)(1)
[6] Id¡

Members of the public throughout the state must have an opportunity to provide comments at these hearings.[7] Additionally, during at least one of the two hearings, the state must provide telephonic or Web conference capabilities to ensure accessibility for anyone who wishes to participate and provide comment.[8]

Finally, federal regulation mandates additional responsibilities for states that are home to "[f]ederally-recognized Indian tribes, Indian health programs, and/or urban Indian health organizations.".[9] These states must consult with the Indian tribes or seek advice from the Indian health organizations and programs prior to submitting their applications to CMS if the project would have a direct effect on those tribes or health organizations and programs.[10]

The public notice and comment is required to be at least 30 days in length and upon completion of that period the state will submit an application to CMS.[11] When submitting their application to CMS, the state must include a summary of the public comments received during the public input process, and if any comments were not adopted, the reasons why.[12] Additionally, the state must specify in their application any modifications to the waiver that they made as a result of the public input process.[13] Once an application is received, CMS has 15 days to determine whether the application is complete.[14] CMS will send the state written notice informing the state of receipt of the complete application, the date on which the Secretary received the application, and the start date of the 30-day federal public notice period.[15] In the

[7] Id¡
[8] Id¡
[9] Id¡
[10] Id¡
[11] Id¡
[12] 42 C.F.R. § 431.408(a)(1)
[13] Id¡
[14] Id¡
[15] https://www.hcbs-ta.org/authority-comparison-chart?field_hcbs_authority_target_id%5B7%5D=7

event that CMS determines that the application is not complete, CMS will notify the state of any missing elements in the application.[16]

After the state is notified by CMS that their application is complete, the federal public notice and comment period commences. Like the state level process, the federal public notice and comment period will last at least 30 days and will allow the general public and stakeholders to submit comments.[17] CMS will publish on www.Medicaid.gov the state's application and associated documents and it will receive public comments through that website.[18] CMS will also post all public comments and maintain an electronic mailing list to notify interested parties that a state's demonstration application is available on the website.[19]

In order to allow enough time for CMS to consider all written public comments, CMS will not render a final decision until 15 days, at a minimum, after the conclusion of the federal public comment period.[20] While CMS will continue to accept comments beyond the 30-day period, they cannot guarantee that comments received after the 30-day comment period will receive adequate consideration due to the need for timely federal review of a state's request and as a result, CMS strongly encourages comments to be submitted within the 30-day federal comment period.[21]

After conclusion of the federal notice and comment period, CMS conducts a thorough review of the waiver proposal to ensure it meets federal requirements and aligns with the goals of the Medicaid program. In determining whether the waiver would further the objectives of

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[16] Id.
[17] 42 C.F.R. §§ 431.416(a), 431.412(b)(1)-(2)
[18] Id.
[19] Id.
[20] Id.
[21] Id.

Medicaid, CMS typically reviews whether the changes would accomplish at least one of the following: increase coverage for low-income people; increase access to care; improve health outcomes; or increase the efficiency and quality of care through delivery system changes.[22]

Additionally, a fundamental requirement that CMS looks for when reviewing an application is cost-neutrality.[23] This means that the cost of providing services under the waiver must not exceed the cost of providing the same services under the traditional Medicaid program.[24] States must demonstrate compliance with this constraint by providing a calculation based on hypotheticals and projections that illustrates what the Medicaid spending would be without the waiver and that the federal spending with the waiver is at least equal to or below the without waiver base.[25]

When granting Medicaid waiver applications, CMS favors those that offer services otherwise not available under traditional Medicaid programs. This concept, referred to as "service flexibility" incudes services such as case management, personal care, respite care and environmental modifications.[26]

CMS' review process also focuses on making sure the state's application will result in services that benefit specific populations, such as individuals with intellectual or developmental disabilities, the elderly, or those with chronic illnesses.[27] By focusing on the unique needs of these populations, states can provide more effective and appropriate care.

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[22] https://crsreports.congress.gov/product/pdf/R/R43357
[23] Id¡
[24] Id¡
[25] Id¡
[26] https://crsreports.congress.gov/product/pdf/R/R43357
[27] Id¡

After rendering a decision, CMS will maintain and publish on its website an administrative record which will include the demonstration application, public comments sent to CMS and, if the application is approved, the final special terms and conditions, and the state's acceptance letter.[28] This rule is final, and will be effective 60 days after publication.[29]

The Reality of Waitlists

States can cover home and community-based services (HCBS) in their state plans, which require such benefits to be made available to all enrollees, or through various waiver authorities that can be targeted to certain populations. Waivers are often used by states to cover HCBS and permit states to limit the number of individuals.[30] A state's ability to cap the number of people enrolled in HCBS waivers can result in waiting lists when the number of people seeking services exceeds the number of waiver slots available. Waiting lists reflect the populations a state chooses to serve, the services it decides to provide, the resources it commits, and the availability of workers to provide services.[31] While waiting lists allow states to manage costs, they also restrict access to HCBS for some individuals who need them. When faced with long wait times, some individuals are left having to find other ways of meeting their long term care needs.

States take various approaches to managing their HCBS waiver waiting lists and eligibility screening for waiver services happens at different times in different states, making it

[28] Id¡
[29] https://www.hcbs-ta.org/authority-comparison-chart?field_hcbs_authority_target_id%5B7%5D=7
[30] https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2023/
[31] https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2023/

difficult to compare waiting lists across states.[32] In 2023, individuals on waiting lists waited an average of 36 months to receive HCBS waiver services, down from 45 months in 2021.[33] The length of a state's waiting list can be influenced by that state's waiting list management approach.[34] In 2023, thirty-two states with waitlists screened individuals for waiver eligibility among at least one waiver, but even among those states, five states did not screen for all waivers.[35] There were six states that did not screen for eligibility among any waivers and those six states (Alaska, Illinois, Iowa, Oklahoma, Oregon, and Texas) account for over half of all the people on waiting lists.[36]

Among those states that screen, the first-come, first-served approach is the most common.[37] This approach encourages individuals to seek enrollment in anticipation of future needs.[38] A state's approach to waitlist management can produce different results depending on the specific waiver service being offered. With regards to waivers for people with intellectual or developmental disabilities, when states take a first-come first-served approach, families will often add their children to waiting lists at a very young age, assuming that by the time they

[32] Medicaid.™ .Child.Health.Ins¡.Program.Payment.™ .Access.Comm'n?State.Management.of.Home_.and. Community_Based.Services.Waiver.Waiting.Lists 0.(8686)?https¿--www¡macpac¡gov-wp_ content-uploads-8686-64-State_Management_of_Home_and_Community_Based_Services_Waiver_Waiting_ Lists¡pdf [perma¡cc-9S6L_FUPX]¡

[33] https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2023/

[34] Medicaid.™ .Child.Health.Ins¡.Program.Payment.™ .Access.Comm'n?State.Management.of.Home_.and. Community_Based.Services.Waiver.Waiting.Lists 0.(8686)?https¿--www¡macpac¡gov-wp_ content-uploads-8686-64-State_Management_of_Home_and_Community_Based_Services_Waiver_Waiting_ Lists¡pdf [perma¡cc-9S6L_FUPX]¡

[35] https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2023/

[36] Id¡

[37] https://www.kff.org/medicaid/issue-brief/a-look-at-waiting-lists-for-medicaid-home-and-community-based-services-from-2016-to-2023/

[38] Id¡

reached the top of the waiting list, their children would have developed the immediate need for services.[39]

With regards to categories of the population on waitlists, people with intellectual or developmental disabilities constitute almost three-quarters (72%) of the total waiver waiting list population.[40] Seniors and adults with physical disabilities account for one-quarter (25%), while the remaining share (3%) includes children who are medically fragile or technology dependent, people with traumatic brain or spinal cord injuries, people with mental illness, and people with HIV/AIDS.[41]

Even though waitlists are a reality for the vast majority of individuals seeking waiver services, most people on waiting lists are eligible for personal care provided through states' regular Medicaid programs or for services provided through specialized state plan HCBS benefits, which can help bridge the gap while they wait to be called off.[42]

[39] Id.
[40] Id.
[41] Id.
[42] Id.